# Presbyterian Support Central - Coombrae Elderly Care

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Coombrae Elderly Care

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 22 September 2016 End date: 23 September 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 42

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

PSC Coombrae is owned by Presbyterian Support Central and provides rest home and dementia level care for up to 44 residents. On the day of the audit there were 42 residents. The service is overseen by a facility manager, who was a registered nurse and well qualified and experienced for the role. The facility manager and clinical nurse manager is supported by staff and the regional operations manager. Residents and family interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff and management.

This audit has identified the following areas requiring improvement; quality management systems, wound care documentation, and completion of short-term care plans.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The service complies with the Code of Health and Disability Consumers’ Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Policies are implemented to support residents’ rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed were familiar with the complaints management process.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The Presbyterian Support Central quality and risk management system is documented. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are documented and benchmarked. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

The clinical nurse manager takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the InterRAI outcomes and other assessments. They are clearly written and healthcare assistants report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate and has been reviewed by a dietitian. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

PSC Coombrae is set within attractive grounds. The buildings have a current building warrant of fitness and a fire evacuation plan. All rooms are single, personalised and have a hand basin. The environment is warm and comfortable. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. Communal areas are spacious and well utilised for group and individual activity. The dining and lounge seating placement encourages social interaction within the rest home. There are communal and dining areas in the dementia care unit appropriate to meet the individual needs. There is a secure outdoor walking path and garden area for the dementia area. Other outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care.

All equipment is well maintained and on a planned schedule. All chemicals are stored securely. Laundry and cleaning services are monitored. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit, there were no residents with restraint or enablers at PSC Coombrae Elderly Care. There is a restraint coordinator for the service, who is the clinical nurse manager. Restraint minimisation education is included in the training programme.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 42 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 4 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) has been incorporated into care. Discussions with staff (one facility manager, one clinical nurse manager, one registered nurse, two recreational officers, and four healthcare assistants) identified their familiarity with the Code of Rights. Interviews with ten rest home residents and three families (two dementia and one rest home) confirmed that the service functions in a way that complies with the Code of Rights. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Seven resident files sampled demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and the registered nurse interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate. The bi-monthly resident meetings are chaired by an independent advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, family and residents confirm residents are supported and encouraged to remain involved in the community and external groups. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written). A complaints register records activity. Complaint forms are visible around the facility. There have been four documented complaints made since the last audit. Three of these complaints relate to the behaviour of one resident. This resident has recently transferred to another facility. All complaints have been appropriately investigated and resolved to the satisfaction of the complainants. One matter had been referred to a Health and Disability Advocate and the matter has now been closed.  The facility manager could describe the complaints management process and the process to follow that aligned with the PSC complaints management policy. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Code of Rights leaflets are available in the front entrance of the facility. Code of Rights posters are on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people’s beliefs and values. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and family interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, family and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service has access to a cultural advisor with links to local Iwi. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there were no residents who identified as Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager and clinical nurse manager along with the resident and family/whānau complete the documentation. Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Discussion with two family members stated they were given information about the service and procedures. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Eight incident forms reviewed for September and August 2016 identified family were notified following a resident incident (link 1.3.8.3). Interviews with healthcare assistants confirmed that family are kept informed. The facility and clinical nurse manager have an open-door policy and residents and family interviewed report that they find the managers very approachable. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Coombrae is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and dementia level of care for up to 44 residents. On the day of the audit there were 42 residents (31 rest home residents [full occupancy] and 11 residents in the 13-bed secure dementia unit). There were no residents on respite. All residents are admitted under the ARRC contract.  The facility manager is non clinical (although was a registered nurse), and has been in the role for four years. The facility manager is supported by a clinical nurse manager who has been in the role for 5.5 years, two registered nurses and a northern regional manager (non-clinical).  Coombrae has a documented mission statement, vision, values and goals included in the 2016-2017 business/quality plan. The 2015-2016 business goals had been reviewed. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During the temporary absence of the facility manager, the clinical nurse manager undertakes the role with the support of the RNs, care staff and the PSC regional manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The service has a documented quality and risk management system. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. Annual resident and relative satisfaction surveys are completed and results collated as per company schedule. Regular meetings are held that involve all staff. Meeting minutes’ reviewed evidence discussion around the results of internal audits.  Monthly accident/incident/reports are completed by the facility manager. There is an online database for recording accidents and incidents with monthly reports to the PSC clinical director. The 2016 meeting schedule includes senior leadership meetings (quality, accidents/incidents and infection control), clinical and staff meetings and resident meetings. Accident/incident, infection control and quality data is collated monthly and reported to head office. There are shortfalls around the analysis of quality data and corrective actions.  Policies and procedures are in place which are developed and reviewed at head office. Staff read and sign to declare awareness of new/reviewed policies and procedures. There is an implemented risk management plan, and health and safety policies and procedures in place including accident and hazard management. The service has a health and safety management system and this includes four monthly health and safety meetings. There is a current the health and safety officer. Emergency plans ensure appropriate response in an emergency. There was a current hazard register for the site. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise. The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the internal PSC benchmarking programme. A monthly incident/accident report is completed, however this does not include an analysis of data collected (link 1.2.3.6). Follow-up assessments by a registered nurse did not always include neurological observations for those residents that had an unwitnessed fall or hit their head or the documentation of a short-term care plan (link 1.3.8.3).  Discussions with the facility manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Seven section 31 incident notification forms were completed (all sighted) since the last audit. The appropriate action has been taken in relation to the matters outlined in the mandatory notifications that were sighted. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including registered nurses and general practitioners, and other registered health professionals are kept. Seven staff files were reviewed (one clinical nurse manager, one registered nurse, two healthcare assistants, one cook, one recreational officer, one cleaner). All staff files reviewed including the appropriate employment and recruitment documents including annual performance appraisals.  The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. A training programme is being implemented that includes eight hours of annual education. The registered nurses and care staff attend PSC professional study days, which cover the mandatory education requirements and other clinical requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per facility calendar. There are seven caregivers who work in the dementia unit. Six have completed the required dementia standards and one staff member, who has not yet worked for 12 months is currently completing the required papers. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager works 32 hours per week and is on call 24/7. The clinical nurse manager works full time Monday to Friday and is also on call 24/7. Two RNs are employed to cover the morning shifts 7 days per week. Care staff interviewed report adequate staff cover. Residents interviewed advised that there are sufficient staff on duty at any one time and that staff are prompt to answer call bells and attend to resident’s needs. There are dedicated cleaning, laundry staff and food services staff. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility and clinical nurse manager screens all potential residents prior to entry. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical nurse manager. The admission agreement form in use aligns with the requirements of the ARRC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (pink) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident’s medicines are stored securely in the medication room/cupboard. Medication administration practice complies with the medication management policy for the medication round sighted. The service uses an electronic medication management system. There was evidence of three monthly reviews by the GP. Registered nurses and healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a pharmacy blister-packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. There were no residents self-administering medication on the day of audit. There are no standing orders. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at are prepared and cooked at PSC Coombrae. There is a five weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks where required. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. Food temperatures when cooked and prior to the food being served to the residents at PSC Coombrae are recorded. Food is transported to the dementia unit by use of a heated Bain Marie. All food services staff have attended food safety and hygiene and chemical safety education. Extra food, sandwiches, puddings, fruit, smoothies, cakes and biscuits were observed prepared and were available in the dementia unit. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly. The InterRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments. Two of the three registered nurses are InterRAI trained. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed described the support required to meet the resident’s goals and needs and identified allied health involvement under a comprehensive range of template headings. The InterRAI assessment process informs the development of the resident’s care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses (RNs) and healthcare assistants (HCAs), follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this is actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.  Wound assessment, monitoring and wound management plans were not fully completed for all wounds. On the day of audit there were five wounds. These included two chronic leg ulcers, one skin lesion, and two skin tears. Not all wounds documentation reflected that wounds have been reviewed in required timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.  Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrate interventions to meet residents’ needs. There was evidence of pressure injury prevention interventions such as resident attendance at exercise programme, use of pressure relieving cushions, daily monitoring of skin, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service follows the Eden principles, demonstrating a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. PSC Coombrae activities programme follows the Eden philosophy and is resident focused. The programme meets the recreational needs of the residents and reflects normal patterns of life. The programme is supported by a team of volunteers.  The service employs two recreational officers who deliver the activities programme, seven days per week. The activity programme is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, dusting, tidying drawers and making own beds (if able).  There is evidence that the residents have input into review of the programme via the resident survey and this feedback is considered in the development of the resident’s activity programme. The activity programme is developed a week in advance.  The service has its own van which is used for outings and transporting residents to attend events in the local community. PSC Coombrae has links with the local preschool, Churches, Idea Services and Canine Friends groups within the community.  An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files sampled reflects the specific requirements of each resident and includes activities which can be used to distract behaviours. Residents interviewed evidenced that the activity programme had a focus on maintaining independence and reducing boredom. Residents in the dementia unit were observed engaging in washing dishes, helping set tables for meals, helping with feeding the birds and participating in games, quizzes and crafts.  In the files reviewed the recreational plans had been reviewed six monthly. Activity participation was noted in the progress notes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The registered nurses evaluate all initial care plans within three weeks of admission. There was at least a three monthly review by the GP. Reassessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status. Seven care plans reviewed included documented care plan evaluations. The RN completing the plan signs care plan reviews. Not all changes in health were addressed by the use of a short-term care plan or the long-term care plan updated. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness which expires on 8 July 2017. PSC Coombrae has a 31-bed rest home area divided into four wings; Rata, Rimu, Nikau and Nikau extension and a 13-bed dementia care unit Rata Haven. Each rest home wing has a small kitchenette. Rata Haven has an open plan dining room area and separate lounge. There is a large recreational room.  There is a maintenance person employed to address the reactive and planned maintenance programme. A number of maintenance issues were noted at audit and a corrective action plan is in place to address these. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43 - 45 degrees Celsius. The facility van with hoist has a current warrant of fitness and registration. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Rata Haven dementia care unit has safe outdoor areas, seating and shade, raised gardens, chook run, and a circular walking path. Rest home residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. One rest home bedroom has a full ensuite and one has a toilet only. All other rooms are single with hand basins. There are adequate numbers of communal toilets/showers in each wing. There are vacant/occupied slide signs. All bedrooms in the dementia unit have hand basins. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The rest home has a large lounge, conservatory, dining area and recreational room with seating placed appropriately to allow for group and individual activities to occur. There are other smaller lounges available.  The dining room in the dementia unit is open plan with the kitchenette and nurses station in close proximity which allows observation of communal areas. There is a separate lounge in Rata Haven which allows for separate group or individual activities to occur. Residents interviewed (ten rest home) were happy with their bedroom space. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Dedicated cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.  Dedicated laundry staff complete all laundry on site in an appropriately appointed laundry. The laundry operates daily from 0800 to 14:30. Residents interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. The facility is well prepared for civil emergencies and has civil defence kits (readily accessible) that are checked monthly. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, torches, batteries and radio.  The backup generator is run for half an hour monthly. Emergency lighting is checked. There is a barbeque and gas bottles for alternative cooking source. The staff interviewed were able to describe the emergency management plan and how to implement this. Fire training and security situations are part of orientation of new staff. A minimum of one person trained in first aid is available at all times. There are call bells in the residents’ rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. In June 2016 PSC introduced a new software programme to assist with benchmarking of data. Summaries of these results are fed back through the senior management meeting and staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinator (clinical manager) provides feedback at staff meetings. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.  The governing body are responsible for the development of the infection control programme and its review. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Due to the small size of the facility, infection control is discussed at staff meetings. The staff meetings are attended by a cross-section of staff from all areas of the service including; management, clinical, kitchen, cleaning, and laundry. The service also has access to the PSC clinical director and nurse consultant, the DHB infection control nurse specialist, public health, and the GPs. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are PSC infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator (clinical manager) has completed a level-7 qualification in infection control. The IC coordinator has maintained skills and knowledge of infection control practice through attendance at the annual PSC infection control nurse peer support day. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, GPs, and expertise within the organisation and external infection control specialists.  The infection control coordinator provides infection control orientation to all new staff. Infection control education is part of the professional nurses and healthcare assistants study days that are held annually. Resident education is expected to occur as part of providing daily cares. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs at PSC Coombrae. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advise and provide feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the senior management and staff meetings. The meetings include the monthly infection control report. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly on-line register. The surveillance of infection data assists in evaluating compliance with infection control practices. Short-term care plans were evidenced as completed for infections. There was an outbreak in April 2016 which was well managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There were policies and procedures in place, should restraints or enablers be required. On the day of audit there were no restraints or enablers in use. The clinical nurse manager is the restraint coordinator. Restraint minimisation education is included in the training programme. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Clinical indicator data is collected for (but not limited to) behaviours, falls, pressure injuries, and skin tears. Quality data captured is then entered into the PSC computer-based Quality Monitoring Programme. The data is discussed at the staff meetings. There is no documented evidence the data entered is trended, analysed or evaluated. | The clinical indicator data is collected but there is no documented evidence to identify this is then analysed, trended or evaluated. | Ensure that all clinical indicator data is documented to reflect it is analysed, trended and evaluated.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The service captures quality data. Internal audits are completed and corrective actions are established for shortfalls. Where areas requiring improvements were noted, corrective action plans were not consistently evidenced. | No corrective action plans were sighted or remedial actions evidenced where clinical indicator data, identified areas requiring improvement. The areas that were above an acceptable benchmark included falls, and behaviours. | Ensure that corrective actions are documented and implemented where areas are identified requiring improvement.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Wound assessment, monitoring and wound management plans are in place for all wounds, however in two of five wounds reviewed not all wound care documentation was fully completed and dressing changes were not evidenced to be occurring in accordance with the prescribed timeframe.  Follow-up assessments by a registered nurse did not always include neurological observations for those residents that had an unwitnessed fall or hit their head. | (i) Two of five wounds did not evidence that dressing changes had been completed within the prescribed timeframe.  (ii) Two of five wounds did not fully document the wound healing process with each dressing change.  (iii) Neurological observations were not evidenced being consistently recorded as per policy for a dementia resident following two unwitnessed falls, one resulting in a laceration to the resident’s forehead. | (i) Ensure wound dressings are completed within the prescribed timeframe; and  (ii) Ensure that RN assessments document progress around wound healing with each dressing change.  (iii) Ensure that neurological observations are recorded within the timeframes specified, as per policy for falls resulting in head injury or suspected head injury.  90 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Low | Two of three dementia and one of four rest home files reviewed did not include updated interventions when there was an acute change in the resident’s needs. | (i) One dementia resident’s file evidenced a recent change in continence needs with frequent episodes of incontinence documented in progress notes, however a follow-up assessment by an RN was not evidenced to have been completed or the care plan updated to reflect the change in health status.  (ii) No short-term care plan was evidenced completed for a rest home resident who had returned from hospital following an incident, which required sutures to a large skin tear. | (i) - (ii) Ensure care plans are updated or short-term care plans developed to address any acute changes in resident’s needs.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.